STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

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R0000	This visit was for a State Residential Licensure Survey. Survey dates: September 5 and 6, 2012 Facility number: 003916 Provider Number: 003916 AIM Number: N/A Survey team: Lora Brettnacher, RN, TC Christi Davidson, RN Census bed type: Residential: 58 Total: 58 Census by payor type: Other 58 Total: 58 Sample: 7 These state findings are cited in accordance with 410 IAC 16.2. Quality review 9/10/12 by Suzanne Williams, RN	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0121	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			

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	Based on record review and interview, the facility failed to ensure health screens were obtained prior to resident contact for 5 of 5 employee records reviewed for health screens. (Dietary Staff #2, CNA #22, RN #23, CNA #24, CNA #33) Findings include: Employee records were reviewed on 9/6/2012 at 10:30 A.M. Dietary Staff #2, Certified Nursing Assistant (CNA) #22, Registered Nurse #23, CNA #24, and CNA #33 did not have health screens completed. During an interview on 9/6/2012 at 11:30 A.M., the Executive Director and the Director of Nursing both indicated the facility did not do health screens because of the cost. They stopped doing the health screens several years ago. Employees did have TB (tuberculosis) screening and drug screening but nothing else.	R0121	R121 Commencing immediately a new more general health screen form will be used in the health screen process for all employees prior to resident contact (see attachment 1). The Director of Nursing will examine the employee for general symptoms, review the forms and either forward to the physician for sign off, (zero symptoms/problems) or forward them to the physician for review when a contrary health symptom of any kind is reported. At that time either a full physical or professional consult will be scheduled for the employee in question with a physician, as appropriate. This process will also be implemented for all existing employees and then a review of all resident health records will be made and reported to the ISDH if any correlations exist. If no correlations are found and no employee health problems of a communicable nature are found then no further report will be made.The initial health screen referred to above will be audited for compliance yearly by the Administrator and or Director of Nursing and or randomly by the Administrator or Director of Nursing. These changes will be completed no later than 10/18/2012 (approximately 30 days from this writing).	10/18/2012

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R0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to identify and document the scope and/or frequency of the services to be provided following completion of the evaluation, for 4 of 7 service plans reviewed in the sample of 7 residents. (Resident #1454, Resident #1414, Resident #203, and Resident #1429)	R0217	**R 217 POC 9/18/2012** Autumn Glen Assisted Living has just transitioned to a computer generated care plan known as YARDI. YARDI has many sections and many layers, not always visible. YARDI does not delineate the care into specific categories using the exact wording of “scope, frequency,	10/22/2012

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	Findings include: 1. Resident #1454's record was reviewed on 9/5/2012 at 2:00 P.M. Resident #1454 had current diagnoses which included but were not limited to: muscle spasms, high blood pressure, esophageal stricture, cerebral vascular accident (stroke), anorexia, anxiety, depression, edema, and peripheral vascular disease. Review of Resident #1454's current service plan/care plan dated 7/2/2012, indicated Resident #1454 had identified needs with communication, refusing medication, adaptation to change, judgement, memory problems related to dementia, wandering, bathing, medication administration needs, and mobility assistance. The service plan/care plan lacked documentation of the specific scope and/or frequency of services to be provided for Resident #1452's identified needs. 2. Resident #1414's record was reviewed on 9/5/2012 at 1:30 P.M. Resident #1414 had current diagnoses which included but were not limited to: legally blind, depression, diabetes, insomnia, and high blood pressure.		need and preference". Therefore: Scope and frequency for residents #1454 and #1414 will be reviewed and added by the Wellness Director. (Completion date NLT 10/22/12) Resident #203 will have individualized diabetes plan reviewed, updated and documented in service plan by the Wellness Director with scope, frequency, need and preference. (Completion date NLT 09/28/12) Resident #1429 will have individualized behavior plan reviewed, updated and documented with scope, frequency, need and preference by the Wellness Director. (Completion date NLT 10/22/12) All residents will have their care plans reviewed and rewritten by the Wellness Director to specifically delineate and include scope, frequency, need and preference under the notes section of the YARDI service plan. (Completion date NLT 10/22/12) Over the next two years, beginning in January of 2012 and ending January of 2014, the Administrator will randomly select 4 residents and make a semi-annual and annual spot check of the resident's service plan. The Administrator will check for the inclusion of personalized services delineated within scope, frequency, need and preference. The plans will then be signed off as having been	

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	Review of Resident #1414's current service plan/ care plan dated 7/13/12 indicated Resident #1414 had identified needs with adaptation to change, hostility, refusal to make decisions, passive and withdrawn, difficulty in decision-making when faced with new tasks or situations, wandering (legally blind and often needed escorts), required care and services at night, assistance with dressing, assistance with bathing, personal hygiene, and mobility. The service plan/care plan lacked documentation of the specific scope and/or frequency of services to be provided for Resident #1414's identified needs. During an interview on 9/6/2012 at 3:00 P.M., the Executive Director and the Director of Nursing were asked to provide documentation of service plans which included the scope and or frequency of the services being provided to the residents, based on their needs identified on their evaluations. They both indicated the current service plans did not include scope and/or frequency of services being provided to the residents. 3. The record for Resident #203 was reviewed 9/5/12 at 11:15 a.m.		checked and copies kept in a separate binder for inspection.	

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	Diagnoses included, but were not limited to, hypertension, depression, seizure disorder, bipolar and non insulin dependent diabetes. A progress note, dated 7/9/12 at 4:00 p.m., indicated, "Resident BS [blood sugar] 439. A [awake] [sign for and] Ox3 [oriented times 3]. voices [sign for no] c/o [complaint]. denies (sic) blurred vision, denies tingling, denies [sign for increase] thirst. Skin warm/dry to touch. Speech clear, VS [vital signs] 157/93 p [pulse] 74. Resident informs nurse of recent snack. PCP [primary care physician] informed...." A progress note, dated 7/9/12 at 5:00 p.m., indicated, "[name of physician] faxed order to monitor resident." A progress note, dated 7/14/12, day shift, indicated, "Res [resident] verbally Aggressive (sic) towards staff." A progress note, dated 7/16/12 at 9:00 a.m., indicated, "Resident shows irate behavior toward other residents during meal time...the aggression cause is unknown. Resident easily redirected... [sign for no] aggression noted remainder of this shift. Resident unusually quiet during lunch."			

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	A progress note, dated 8/8/12 at 10:00 a.m., indicated, "[name of physician] here. New order D/C [discontinue] Zoloft [antidepressant medication] 75, start Zoloft 100 mg [milligrams]." A current recapitulation for Resident #203 with a physician's order dated 10/29/11, indicated accuchecks [obtaining blood sugar result] two times a day on Monday and Thursday. A document, provided by the DoN [Director of Nursing] on 9/5/12 at 1:30 p.m. and identified as Resident #203's service plan, lacked documentation of individualized services provided by the facility related to Resident #203's diagnoses of diabetes. The service plan lacked documentation of individualized services provided by the facility related to aggressive behavior. 4. The record for Resident #1429 was reviewed on 9/5/12 at 11:25 a.m. Diagnoses included, but were not limited to, depression with anxiety, seizures, and behaviors. A progress note, dated 8/31/12 at 1:00 p.m., indicated, "Staff reports resident yelling at them...Res. upset [sign for secondary to] not being safe to use			

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	electric w/c [wheelchair]. Res. slammed walker into door/wall area...Writer...allowed him time to vent frustrations. Writer then redirected res...Administrator notified...." A document, provided by the DoN on 9/5/12 at 3:40 p.m. and identified as Resident #1429's service plan, lacked documentation of individualized services provided by the facility related to behaviors. During an interview on 9/5/12 at 3:40 p.m., the DoN and the Administrator indicated the above documents were the active service plans for Resident #203 and Resident #1429.			